



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHARLES W KENNEDY JR MD
601 TEXAS TRAIL SUITE 201
CORPUS CHRISTI 78411

Respondent Name

HARTFORD INSURANCE COMPANY OF

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-13-0511-01

MFDR Date Received

October 22, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting in getting payment for services rendered for the above listed Workers' Compensation Claimant. [Injured Worker] was seen for a Post DDE RME. The evaluation took place back on January 23, 2012 with Dr. Charles W. Kennedy Jr in Harlingen, Texas. Dr Kennedy was to address MMI & IR which he did."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No insurance carrier response received

Response Submitted by: n/a

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2012	CPT Code 99456-RE-NM	\$350.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 *Texas Register* 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits:

- No explanation of benefits received

Issues

1. Was CPT Code 99456-RE-NM billed appropriately according to 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-RE-NM in the amount of \$350.00 for one unit for a Maximum Medical Improvement (MMI) and Impairment Rating (IR) testing.

Review of the submitted documentation provided supports that a DWC-22 (Required Medical Examination (RME) – Request for Agreement/Request for Order) request by the Insurance Carrier Representative to address the following examination's of Maximum Medical Improvement (MMI) and Impairment Rating (IR).

The RME report provided by the provider that rendered the examination for the injured worker shows that the following issues to be addressed are Maximum Medical Improvement (MMI) and Impairment Rating (IR) one body area rated using range of motion however the provider has mentioned in the report that the injured worker is not at Maximum Medical Improvement (MMI).

Per 28 Texas Administrative Code §134.204 states (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include, (A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added, (3) The following applies for billing and reimbursement of an MMI evaluation, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350, (4) The following applies for billing and reimbursement of an IR evaluation, (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form, (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas, (i) Musculoskeletal body areas are defined as follows, (I) spine and pelvis; II) upper extremities and hands; and, (III) lower extremities (including feet), (ii) The MAR for musculoskeletal body areas shall be as follows, (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used, (II) If full physical evaluation, with range of motion, is performed, (-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area.

The total Mar for the services provided and documented per the RME report is \$650.00 however the provider did not bill with the correct modifier. Therefore, CPT Code 99456-RE-NM does not support the services billed.

2. The respondent issued payment in the amount of \$0.00. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

2/26/14
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.